ABC Wellness & Rehab

Name: ____ Date _________________

What is your major complaint? ____
How and when did it start? ____
____

Frequency of your Symptoms:
____ Constant ____ Intermittent _____ Frequent _____ Occasional

MEDICAL HISTORY QUESTIONAIRE

Are you working now?.. Yes / No ____________________________
Do you have Hepatitis C or B? (circle one)……………….. Yes/ No ____________________________
Have you tested HIV positive?..Yes/ No ____________________________
Do you have a Heart problem?... Yes / No ____________________________
Do you have a cardiac pacemaker?.........................……... Yes / No ____________________________
Do you have a metal implant?... Yes / No ____________________________
Do you have any joint replacements?.................................. Yes / No ____________________________
Do you have a history of cancer?...Yes / No ____________________________
Do you have high blood pressure?.......................................Yes / No ____________________________
Do you have a history of high cholesterol?.......................... Yes / No ____________________________
Do you have diabetes?... Yes / No ____________________________
Do you have a history of seizures?...................................... Yes / No ____________________________
Do you smoke?... Yes / No ____________________________
Do you drink alcohol?..Yes / No ____________________________
Do you drink caffeinated beverages?...................................Yes / No ____________________________
Any recent X-rays/MRI/CT?.. Yes / No ____________________________
If yes, when? _____________________

Have you ever had Physical Therapy before?....................... Yes / No ____________________________
If yes, please describe: ____
____
____

Previous Surgeries: ____

Have you ever had anything similar before?.......... Yes / No
What makes your pain worse? (ie sitting, standing, etc.): ____
What eases your pain? ____

Rate your pain at this time: 0 1 2 3 4 5 6 7 8 9 10
At its Best: 0 1 2 3 4 5 6 7 8 9 10
At its Worst: 0 1 2 3 4 5 6 7 8 9 10
What are you unable to do because of your pain/problem? ____
____

Name of your Primary Care Physician: __________________________________ Date of Last Exam: ______
Are you seeing any specialists?: Yes / No If yes, name and specialty: ______________________________

(For women)
Are you or could you be pregnant at this time? Yes / No
Date of: Last menstrual period: _________ Last Pap Smear: __________ Last mammogram: ___________
Complications (if any) with childbirth? ____

Have you experienced (circle):
Abnormal Pap Smear Breast Lump/Pain Vaginal Discharge Abnormal Bleeding

MEDICATIONS: (please list all medications you are currently taking and reason for taking it)

____________________________ ____________________________ ______________________________
____________________________ ____________________________ ______________________________
____________________________ ____________________________ ______________________________
____________________________ ____________________________ ______________________________

FAMILY HISTORY: (mark if any of your blood relatives have had any of the following)

Condition	**Relationship to you**	**Condition**	**Relationship to you**
Arthritis	_____________________	Heart Disease/Stroke	_______________________
Asthma	_____________________	High Blood Pressure	_______________________
Cancer	_____________________	Kidney Disease	_______________________
Diabetes	_____________________	Other:	_______________________

In the space below, please write down anything else you believe he doctor should know regarding your care so that he may be better able to assist you.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for an error or omissions that I may have made in the completion of this form.

Patient Signature Date